Designing Provider Incentive Programs to Promote the Provision of Better Quality Health Care

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Starting Point

- We all know that health care quality for all of us, including Medi-Cal beneficiaries, is not as good as it should be, or needs to be.
- To improve quality, we need to change the behavior of consumers, providers, insurers, and government.
- Our conversation today will address one technique for changing provider behavior: *use of incentives and rewards*.

What does it take to improve quality?

"We have learned that quality improvement is not a project. It is a lifetime obsession that requires continual organizational focus, resources, and course corrections."

- Matthew Chin, Primary Care Development Corporation, New York City

Incentives and Rewards

- Incentive: Any means to motivate providers to behave in a certain manner, e.g., adhere to evidence-based guidelines
- Reward: Awarding providers a tangible benefit for having behaved in a certain manner.

Traditionally…

"In health care, everybody is used to getting paid the same whether they have the best care or the worst care, and that's insane."

- Tom Scully, former CMS Administrator

Shouldn't providers be delivering quality care now?

"We don't believe in paying more for what providers should be doing already."

- senior executive of one of the largest U.S. insurers, January 2007

"Pay for performance assumes you should have to pay more for high quality."

- Michael Porter, Harvard Business School

Yes.
But it's not always happening.

- Simply requiring providers to meet standards has not achieved excellence.
- Few external incentives for providers to invest in quality improvement.
- Current payment systems sometimes provide financial *disincentives* to quality care provision.

Why we are here today

- An incentive and reward program is one potentially powerful mechanism for modifying provider behavior, and improving quality of care.
- Absent behavior change, quality will not improve.

Presentation Overview

1. "Value" and I&R in a Medicaid context
2. Developing a I&R initiative
3. Incentive and reward models
4. Determining incentive targets
5. How much money and where to get it?
6. What lessons have been learned?

“Value” in a Medi-Cal Context

- access to care
- quality of care
- member satisfaction
- racial and ethnic disparity reduction
- efficiency
- cost management

A word on use of I&R for reduction of racial and ethnic disparities

- 2006 Massachusetts legislation requires that beginning in state FY 2008, hospital rate increases are to be linked to quality indicators, including reductions in racial and ethnic disparities in care
- We are not aware of any other I&R applications to reduce racial and ethnic disparities

Examples of “Rewards” in I&R

- Payment for the achievement of a pre-specified performance goal.
- The use of non-monetary rewards, such as public reporting and recognition to motivate providers.
- Preferential auto-assignment of Medi-Cal members to high-performing providers.

Examples of Performance Goals

- Pay for Outcomes: Achievement of a certain pre-specified clinical goal.
- Pay for Process: Compliance with certain quality improvement processes or protocols.
- Pay for Participation: Simple participation in a designated quality improvement activity.

Non-Financial Incentive Models

1. Performance Profiling
2. Public Recognition
3. Technical Assistance
4. Practice Sanctions
5. Auto-assignment

Financial Incentive Models

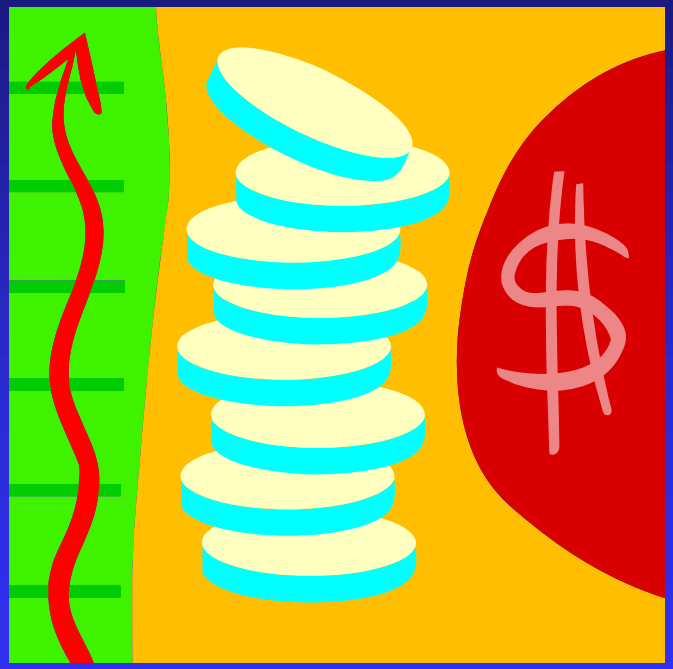
1. Pay for Participation
2. Quality Grants
3. Bonus for achievement of a threshold.

Financial Incentive Models

5. Tiered bonus for achievement of thresholds.
6. Tiered bonus based on comparative ranking
7. Bonus for demonstration of improvement
8. Performance-based fee schedule

Financial Incentive Models

8. Compensation at risk
9. Variable cost sharing (steerage)



A few words on steerage…

- "Changing physician behavior is a windmill that has absorbed billions of dollars and millions of hours of tilting, with little evidence of impact. While the objective is noble, the business case is highly suspect. Identify the best performing physicians and direct your patients to them. Let others shatter their lances." - www.joepaduda.com
- "Patient flow to excellent providers in addressing a medical condition is a much more powerful incentive than a small bonus because it feeds the virtuous circle of value improvement from volume and experience."

  – Michael Porter, Harvard Business School

A few words on steerage…

- Steerage may possibly work for commercial insurance products with higher income populations.
- No one knows if it can work for Medi-Cal, and there are good reasons to be skeptical:
  - existing access problems
  - member may get service without paying co-pay
  - difference in co-pay between levels will be small
  - problems generating sufficient performance data

Designing an I&R initiative

- An iterative process.
- Relationship between targeted providers, quality goals, available measures, available data, etc.
- Keep it simple.
- Be prepared to revisit design as decisions are made.

Resources to consider when designing a strategy

- Dudley R.A. and Rosenthal M.B. “Pay for Performance: A Decision Guide for Purchasers”, Agency for Healthcare Research and Quality, April 2006. Accessible at www.ahrq.gov/qual/p4pguide.htm

- Bailit Health Purchasing, LLC. “Incentives and Rewards Best Practices Primer: Lessons Learned from Early Pilots”, The Leapfrog Group, July 2006. Accessible at www.chcf.org/topics/chronicdisease/index.cfm?itemID=124237

Resources to consider when designing a strategy

- Llanos K., Rothstein J., Dyer MB and Bailit M. “Physician Pay-for-Performance in Medicaid: A Guide for States”, Center for Health Care Strategies, March 2007. Accessible at www.chcs.org.

Consider off-the-shelf programs

- Bridges to Excellence
  - Three programs; two to be released in 2007
  - *Diabetes Care Link*: offers MDs a bonus based on demonstrating good control of diabetes in patients
  - *Physician Office Link*: offers MDs a bonus for investing in information technology and care management tools
  - *Cardiac Care Link*: offers MDs a bonus based on demonstrating that they are top performers in providing cardiac care

Consider off-the-shelf programs

- Leapfrog Hospital Rewards Program
  - Identifies five conditions that can deliver significant opportunity for increased quality and affordability: coronary artery bypass graft, angioplasty, heart attack care, community acquired pneumonia and deliveries/neo-natal care.
  - Has designed an actuarially sound mechanism for rewarding hospitals for excellence and improved performance in these important clinical areas.

Develop your I&R vision

- What aspect(s) of health care delivery do you want to improve?
- What behaviors do you want to change?
- Which providers will be affected?
- What are the pros and cons of targeting individual providers or groups?
- What do you desire as an outcome of your I&R initiative?

Determining whom to target

- Consider different types of providers and organizations, including:
  - Integrated delivery systems
  - Physician-hospital organizations
  - Hospitals
  - Medical groups
  - Individual physicians
  - Nursing facilities

Determining whom to target

1. Which types of providers drive quality in areas most important to you?
2. For which providers do you currently measure performance?
3. Do these providers work independently or in multi-disciplinary teams?
4. With which providers are you likely to have:
   - a collaborative relationship?
   - common objectives for quality improvement?
   - more leverage?

How much money do you need?

- Consider the financing of the incentives and funding for the development, implementation, refinement, and evaluation activities related to the I&R program.

How much money do you need?

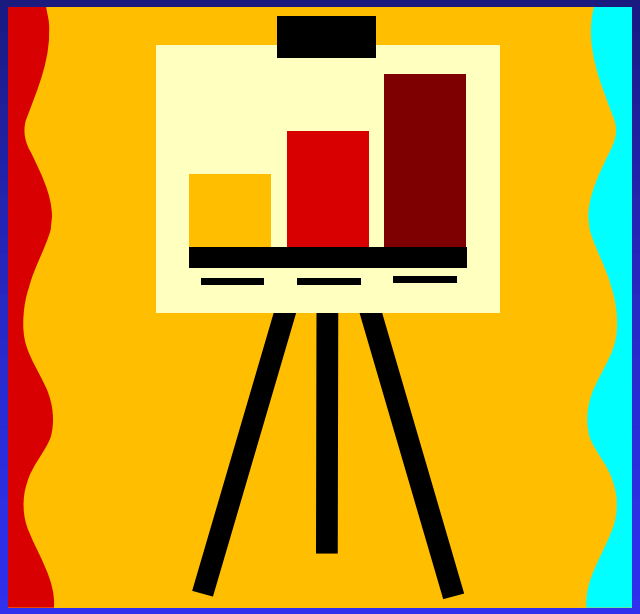
- Significant staff time and data analysis are needed for I&R development and implementation phases.
- Costs will vary considerably depending on the data collection and measurement approaches.
  - RIPA estimated that its state-of-the-art profiling and I&R initiative cost an estimated $1.15 million per year in software, staff, and production costs.

Consider Non-Financial Incentives

- Purchaser, health plan, and provider I&R experience has shown that the use of multiple reinforcing incentives, including non-financial incentives, enhances the likelihood of desired provider behavior change.

Data can be an incentive

- Providers want better data on their performance.
- Demonstrating that a performance gap exists between actual (what is provided) and ideal (what should be provided) care can be an important motivator for providers.



Financing Medicaid I&R Initiatives

- Foundation funds, federal grants, or in-kind services can help defray I&R development and implementation costs.
- These funding sources rarely assist with funds for the actual incentive payment(s).
- Whatever the source of the funds for the I&R program, it is essential to assess what will be required and where the funds and resources will come from and if the state will qualify for FFP for the related costs before proceeding.

How large does the financial incentive need to be?

- It depends.
- Incentive programs are more effective at engaging providers when the I&R program affects a “significant” portion of a provider’s business.
- The importance and level of financial rewards vary across and within provider groups and health care markets and is affected by other factors such as: provider resources, provider alignment with the goals of the I&R initiative, and concurrent incentive strategies.

How large does the financial incentive need to be?

- There is no formula for exactly what portion of a provider's business is "significant" enough for a I&R initiative to be meaningful and effective.
- While not proven, many insurers believe that a financial reward must equal approximately 10 percent of total provider payments to be effective in motivating provider behavior change.

Trude S, Au M, and Christianson JB. "Health Plan Pay-for Performance Strategies" *The American Journal of Managed Care*, 2006; 12:537-542.

How large does the financial incentive need to be?

- Evidence from commercial I&R experiences demonstrates that small financial incentives and/or contradictory public report cards by different sponsors with little market leverage are unlikely to be effective.
- Even with small financial incentives, states and plans can obtain additional leverage by coordinating with other quality improvement initiatives locally and nationally.

I&R Financing Approaches

- Withhold portion of payment and pay it back later, contingent on performance.
- Budget a pool of dollars for bonus payments.
- Fund “challenge pools” where unearned bonus monies or unearned withhold payments are paid out to those that excel on certain measures.
- Reallocate monies collected as penalties and redistribute them as incentives for performance.
- Link rate increases to providers meeting certain I&R participation or performance standards.

Does I&R work?

YES. Targeted quality incentives can improve care, reduce medical expenditures, and increase the value of limited health care resources.

but:

- not always, not overnight, and not without effort;
- collaboration and trust are essential to provider engagement and success.

Provider I&R Success Stories

- Local Initiative Rewarding Results grant-funded initiative
- Integrated Healthcare Association medical group report card and coordinated plan incentives
- BCBSMI hospital reporting and incentives (MI)
- Bridges to Excellence physician recognition and coordinated purchaser incentives (initial pilots in regions of KY, MA, NY, OH)
- Excellus/RIPA physician profiles and financial incentives (Rochester NY)

I&R Lessons Learned

From the research literature…

- Lindenauer PK et. al. “Public Reporting and Pay for Performance in Hospital Quality Improvement”, *New England Journal of Medicine*, Volume 356:486-496, February 1, 2007.
- Does pay-for-performance improve the quality of health care?
  Annals of Internal Medicine, Volume 15;145(4): 265-72, August 2006.
- Rosenthal MB et. al."Early Experience With Pay-for-Performance: From Concept to Practice". *JAMA* 294 (14): 1788-1793, 2005.

I&R Lessons Learned

- Provider engagement must begin early.
- Incentives need to be meaningful to providers.
- Combination of financial or non-financial incentives is more effective than one strategy alone.
- Incentive targets need to be based on measurable actions over which providers have control.
- Data sources and calculations need to be acceptable to providers.
- Make certain that you don't only allocate additional funds to those who are already the best.

I&R Lessons Learned

- Incentives should be easy to administer and easy for providers to understand.
- Presentation of profile comparison data can encourage conversation, sharing of best practices and competition on quality.
- Joint setting of performance thresholds allows for cooperative learning.
- Clinical incentives need to be constant over a period of *at least* 2 years to be effective.

I&R Lessons Learned

- And finally…be prepared to address provider suspicion and distrust.

  "Pay for performance: It's about cost control, not quality."

  - William G. Plestad III, MD, President American Medical Association

  American Medical News, February 19, 2007

Questions and Discussion

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